IDAHO HEALTHCARE DIRECTIVE REGISTRY
Your voice. Your choice.

IDAHO DEPARTMENT OF HEALTH & WELFARE
DIVISION OF PUBLIC HEALTH

Advance Directive Registration Form

This form is **required** to add a hard copy Advance Directive or POST to the registry. Email the form and Advance Directive documents to IHDR@dhw.Idaho.gov or mail to the address below (***email preferred***). Please call 208-334-5501 for questions.

I want to:

☐ Store a copy of my healthcare Advance Directive and/or POST in the Registry.

☐ Replace my Advance Directive currently in the Registry, number _____, with the one included.

☐ Revoke my healthcare Advance Directive from the Registry.

The personal information below is provided with this request to store my Advance Directive the Idaho Healthcare Directive Registry. I certify the Advance Directive, Durable Power of Attorney for Healthcare, and/or POST that accompanies this agreement is my effective healthcare directive executed in accordance with State of Idaho laws.

I understand registry use is entirely voluntary and not required. Registration only makes these documents more accessible to healthcare providers, healthcare organizations, and individuals that I choose.

*REGISTRATION CONFIRMATION WILL BE SENT TO THE REQUESTOR VIA **EMAIL ONLY**. ADVANCE DIRECTIVE DOCUMENTS WILL **NOT BE RETURNED**.*

Fill in this registration form and email/enclose it with a COPY of your healthcare Advance Directive and/or POST.

First Name, Middle Name, Last Name *required		Date of Birth *required
Address *required		Gender(M/F/other)*required
City, State, Zip Code *required	Phone *required	Last Four SSN *(optional)*
Email Address * cannot not be used by another registrant, if no email address put "none"		

ADDRESS TO SEND ADVANCE DIRECTIVE REGISTRATION CONFIRMATION VIA EMAIL, IF DIFFERENT FROM ABOVE.

First Name, Last Name	
Address	City, State, Zip Code
Phone	Email Address

_____
Signature of Registrant

_____
Date

Sign, date, and send to:
Email (preferred): IHDR@dhw.Idaho.gov
OR
Idaho Healthcare Directive Registry
450 W State Street, 4th Floor
P.O. Box 83720
Boise, Idaho 83702-0036

IDAHO DURABLE POWER OF ATTORNEY FOR HEALTHCARE AND LIVING WILL

Print Name: _____ **Date of Directive:** _____

Address: _____ **Birth Date:** _____

An Advance Directive is a general term used to describe this document. There are two parts: 1) the Durable Power of Attorney for Healthcare and 2) the Living Will. The purpose of this form is to help you plan ahead so your loved ones and healthcare team know what care you want if you experience a medical crisis and cannot speak for yourself. Your name, address, birth date, date of directive, and signature is required. All other questions and decisions are optional.

DURABLE POWER OF ATTORNEY FOR HEALTHCARE

This portion of my Advance Directive creates a durable power of attorney for healthcare. This power of attorney will remain in effect if I become incapacitated and shall be effective **only** when I am unable to communicate or make my own healthcare decisions.

For the purposes of this Advance Directive, "healthcare decision" means:

- Consent
- Refusal of consent; or
- Withdrawal of consent

to any care, treatment, or procedure to maintain, diagnose or treat an individual's medical condition.

1. **DESIGNATION OF AGENT.** I designate and appoint the following individual as my healthcare agent to make healthcare decisions for me as authorized in this Advance Directive:

Name of Healthcare Agent: _____

Relationship: _____ Phone Number of Healthcare Agent: _____

Address: _____

2. **DESIGNATION OF ALTERNATE AGENTS.** If the person designated as my healthcare agent in paragraph 1:

- Is not available or becomes ineligible to act as my agent to make a healthcare decision for me; or
- Loses the mental capacity to make healthcare decisions for me; or
- If I revoke that person's designation or authority to act as my agent to make healthcare decisions for me,

then I designate and appoint the following person to serve as my agent to make healthcare decisions for me as authorized in this Advance Directive (*You are not required to designate any alternate agents, but you may do so. Any alternate agent you designate will be able to make the same healthcare decisions as the agent you designated in paragraph 1 above, in the event that person is unable or ineligible to act as your agent.)*

A. Name of First Alternate Agent: _____

Relationship: _____ Phone Number of Alternate Agent: _____

Address: _____

B. Name of Second Alternate Agent: _____

Relationship: _____ Phone Number of Alternate Agent: _____

Address: _____

If any of the agents designated above is my spouse, and our marriage is dissolved (divorce or annulment) after creation of this Advance Directive, appointment of that agent is automatically revoked as of the date of the dissolution.

None of the following may be designated as your agent or alternate agent:

- *Your treating healthcare provider;*
- *A non-relative employee of your treating healthcare provider;*
- *An operator of a community care facility; or*
- *A non-relative employee of an operator of a community care facility.*

3. **GENERAL STATEMENT OF AUTHORITY GRANTED.** I hereby grant to my agent full authority to make healthcare decisions for me to the same extent that I could make such decisions for myself if I had the capacity to do so. My agent shall make healthcare decisions that are consistent with my desires as stated in this Advance Directive or otherwise made known to my agent verbally or in writing. This includes, but is not limited to, my desires concerning obtaining, refusing, or withdrawing life-sustaining care, treatment, procedures. This authority includes following my desires as stated in a living will or similar document executed by me.

4. **INSPECTION AND DISCLOSURE OF INFORMATION RELATING TO MY PHYSICAL OR MENTAL HEALTH.**

A. General Grant of Power and Authority. Subject to any limitations in this Advance Directive, my agent has the power and authority to do all of the following:

- Request, review and receive any information, verbal or written, regarding my physical or mental health including, but not limited to, medical and hospital records;
- Execute on my behalf any releases or other documents that may be required in order to obtain this information;
- Consent to the disclosure of this information; and
- Consent to the donation of any of my organs for medical purposes.

B. HIPAA Release Authority. My agent shall be treated as I would be with respect to my rights regarding the use and disclosure of my individually identifiable health information or other medical records. This release authority applies to any information governed by the Health

Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. 1320d and 45 CFR 160 through 164. I authorize any physician, healthcare professional, dentist, health plan, hospital, clinic, laboratory, pharmacy, or other covered healthcare provider, any insurance company, and the Medical Information Bureau, Inc. or other healthcare clearinghouse that has provided treatment or services to me, or that has paid for or is seeking payment from me for such services, to give, disclose and release to my agent, without restriction, all of my individually identifiable health information and medical records regarding any past, present or future medical or mental health condition, including all information relating to the diagnosis of HIV/AIDS, sexually transmitted diseases, mental illness, and drug or alcohol abuse. The authority given my agent shall supersede any other agreement that I may have made with my healthcare providers to restrict access to or disclosure of my individually identifiable health information.

5. **SIGNING DOCUMENTS, WAIVERS AND RELEASES.** When necessary to implement the healthcare decisions that this Advance Directive authorizes my agent to make, my agent has the authority to execute on my behalf all of the following:

a) Documents titled, or purporting to be, a "Refusal to Permit Treatment" and/or a "Leaving Hospital against Medical Advice"; and
b) Any necessary waiver or release from liability required by a hospital or physician.

6. **PRIOR DESIGNATIONS REVOKED.** I revoke any prior durable power of attorney for healthcare.

Continue to Living Will on next page.

LIVING WILL
Directive to Withhold or to Provide Treatment

This portion of my Advance Directive creates my Living Will which allows me to make choices about any life-sustaining medical treatment I want or do not want. This Advance Directive shall be effective only if I am unable to communicate my instructions and:

A. I have an incurable injury, disease, illness or condition AND a medical doctor who has examined me has certified:

i. That such injury, disease, illness, or condition is terminal; and
ii. That the application of artificial life-sustaining procedures would serve only to prolong artificially my life; and
iii. That my death is imminent, whether or not artificial life-sustaining procedures are utilized.

OR

B. I have been diagnosed as being in a persistent vegetative state.

IF I AM IN ONE OF THE ABOVE SITUATIONS, my choices are as follows: *(Choose Box 1, 2, or 3 below, check the box, and initial the line after the box you checked).*

Regardless of the box chosen, pain and symptom management (comfort care) will be provided.

1. ☐ _____ If my death is imminent, I do not want life-sustaining medical treatment or procedures to be started and, if already started, I want all such treatment and procedures to be withdrawn, including withdrawal of artificial nutrition (such as feeding tube) and hydration.

OR

2. ☐ _____ If my death is imminent, I do not want any artificial life-sustaining medical treatment, care or procedures except for artificial nutrition and hydration as follows:

*Check **one** box* and initial the line after the box you checked:

A. ☐ _____ Only artificial hydration
B. ☐ _____ Only artificial nutrition
C. ☐ _____ Both artificial hydration and nutrition

OR

3. ☐ _____ If my death is imminent, I want all medical treatment, care, and procedures necessary to sustain my life, including artificial nutrition and hydration.

SPECIAL PROVISIONS (OPTIONAL)

The following are additional statements of my wishes. *Check all boxes that apply and initial on the line after the boxes you checked:*

IF I AM DIAGNOSED AS PREGNANT:

☐ _____This Advance Directive shall be honored in its entirety during the course of my pregnancy.

OR

☐ _____I direct the following treatment ☐ shall ☐ shall not be withheld or withdrawn:

_____

_____

_____

OR

☐ _____My instructions regarding medical care shall have no force during my pregnancy except that my Healthcare Agent is authorized to make such decisions for me.

☐ _____ If I have a medical condition from which I am not imminently dying, and from which I will not likely recover, am unable to think or communicate, and am dependent on others for my care, I do not want life-sustaining medical treatment or procedures to be started. If already started, I want all such treatment and procedures to be withdrawn, including withdrawal of artificial nutrition (such as feeding tube) and artificial hydration. In such condition, I want care to be focused on my comfort.

☐ _____ Other situations as described in the box below *(If needed, attach, and sign additional pages.):*

This section is not required and may be used to describe your desires and wishes.

Some examples of what may be included here are: no admission to Intensive Care Unit; resuscitation preference*; people you do not want involved in your medical decisions; limitations to treatment options, including time limits; willingness to have a permanent feeding tube; funeral and burial wishes; organ/body donation, etc.

*NOTE: A POST form contains specific medical orders, including resuscitation, for individuals with a serious illness or nearing the end of life. Ask your healthcare provider for more information.

IDAHO POST FORM VERIFICATION. *Check one box and initial the line after the box you checked:*

☐ _____I have completed a Physician Orders for Scope of Treatment (POST) form that contains directions that may be more specific than, but are compatible with, this Advance Directive. I hereby approve of those orders and make them a part of this Advance Directive.

OR

☐ _____ I have not completed a Physician Orders for Scope of Treatment (POST) form. If I complete a POST form at a later date, then this Living Will shall be deemed modified to be compatible with the terms of the POST form.

SIGNATURE OF PRINCIPAL. *You must sign this Durable Power of Attorney for Healthcare and Living Will for it to be valid.*

I understand the full importance of this Advance Directive and am mentally competent to make this Advance Directive. No participant in the making of this Advance Directive or in its being carried into effect shall be held responsible in any way for complying with my directions.

The authority given my agent has no expiration date and shall expire only in the event that I revoke the authority in writing.

I sign my name below to this Idaho Durable Power of Attorney for Healthcare and Living Will on the date at the beginning of this document.

_____
Signature